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Final report of meeting on policy-oriented monitoring of equity in health and health care

Geneva, 29 September–3 October 1997

Organized together with
the Council for International Organizations of Medical Sciences
and the NGO Forum for Health

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WORLD HEALTH ORGANIZATION

FINAL REPORT OF

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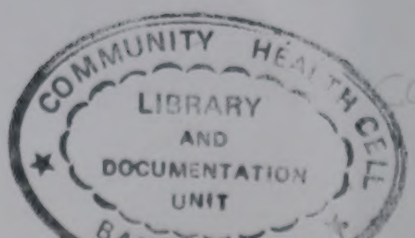

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The challenge of promoting equity in health and health care is the major theme of the Equity Initiative launched by the World Health Organisation and Sida in 1995. One of the strategies adopted in focusing on equity has been the development of indicators to monitor equity, with an emphasis on using these data to influence the policy process.

To further advance this work, the Meeting on Policy-Oriented Monitoring of Equity in Health and Health Care was convened from 29 September to 3 October 1997 at WHO headquarters in Geneva. It was co-organized by WHO, the Council for International Organizations of Medical Sciences (CIOMS) and the Non-Governmental Forum for Health. Participants represented Ministries of Health, universities, research institutions, non-governmental organizations, donors and WHO regional and country offices.

This technical meeting was designed to assist WHO in developing the next steps forward in this major initiative focused on achieving greater equity in health and health care. Although the primary concern of the meeting was policy-oriented monitoring, it was intended that this be seen in the context of the broader range of activities proposed by the initiative including policy development, implementation and advocacy but also be seen in relation to WHO's new policy *Health for all in the 21st Century.*

The meeting acknowledged that a precise definition of equity is not available. However there was agreement that health inequities exist when there are inequalities in health status, risk factors, or health service utilisation between individuals or groups, that are unnecessary, avoidable and unfair. Equity in health requires equity in the distribution of the determinants of health including, but not limited to, health services. Even in relatively affluent nations that emphasize equity in access to services, there are significant inequalities in health status that reflect more fundamental social inequalities in socioeconomic status, education, working and living conditions.

Reducing inequalities in health status to the point where we can judge them unavoidable and fair, would therefore require: (1) special steps in the health sector to compensate for inequalities in risk factors that arise from other inequalities (socioeconomic, gender etc.) and (2) further efforts to reduce these other inequalities through intersectoral action.

Inequity is a problem in all regions and all countries. Socioeconomic inequalities are the most important determinants of avoidable inequalities in health status, with health care services playing a lesser role. Presentations showed that there is a need for disaggregated data at all levels to allow for the identification of inequities and that both the quality and practical use of existing data should be markedly increased. The use of routine data from the health sector needs to be supplemented with additional routine information from other sectors, e.g. the census or routine household surveys conducted by labour, commerce, agriculture, social welfare or other sectors, in order to identify neglected groups. The most disadvantaged are not a homogenous group of society; there are significant differences between, e.g. the "moderately poor" and the extremely poor or poorest. Measures of deprivation should be sensitive to these socioeconomic differences with health consequences. Policy makers need to be able to be effective advocates for greater equity, even when evidence of short-term overall economic gain is lacking.

Four key criteria for selecting indicators for monitoring equity in health and health care were recommended: Relevance to policy on equity in any relevant sector; accessibility of disaggregated data; simplicity; and meeting standard scientific and ethical criteria.

Different ways of formulating an equity target with a given indicator were discussed. Formulating an equity target is probably more important than which specific indicator is selected, as it is the target that is explicit about comparisons among the more and less advantaged. Using child mortality rates, the following examples illustrate what is meant by an equity target, as contrasted with a generic target that does not address issues of equity:

- A generic target: By the year ____, reduce child mortality to x%.

- Contrasted with possible equity targets, e.g.:
  By the year _____, reduce child mortality to x% overall, and reduce the disparities in child mortality between the highest and lowest income quintiles by z%; or

  By the year _____, reduce child stunting to x% overall, and reduce the disparity in stunting rates between girls and boys by y%.

The recommended indicators are summarized in the table below:

Table: Key indicators for monitoring equity in health and health care

Indicator categories	**Indicators measuring differences between population groups**
1: Health determinants indicators:	Prevalence and level of poverty Educational levels Adequate sanitation and safe water coverage
2: Health status indicators:	Under 5-year child mortality rate Prevalence of child stunting *Recommended additional indicators*: Maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1-4 year old mortality rate expressed separately
3: Health care resource allocation indicators:	Per capita distribution of qualified personnel in selected categories. Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels. Per capita distribution of total health expenditures on personnel and supplies, as well as facilities.
4: Health care utilization indicators:	Immunisation coverage Antenatal coverage % of births attended by a qualified attendant Current use of contraception

In relation to WHO's new policy *Health for All in the 21st Century*, it was emphasized that health for all is equity. Equity is a core value of the new policy and the policy introduces equity-oriented indicators, in particular, child health and child growth. In order to achieve equity it should be made an explicit criterion for priority-setting. Health systems have to act and ensure universal access to adequate quality care and adopt life-span approaches which give priorities to prevention and health promotion.

The meeting identified a range of obstacles to equity, e.g. lack of clarity of the concept, lack of awareness among policy-makers, lack of data, lack of analysis of existing data, management of the health sector, general acceptance of inequities and global issues such as the role of private companies. Strategies for overcoming these obstacles and advance equity were recommended.

WHO needs to be bolder, and speak out on controversial issues such as privatization, unhealthy industries, unhealthy trades and unhealthy business practices. Progress on equity will not be achieved by a "business as usual" approach. WHO should disseminate evidence of where pursuing economic growth without a systematic and explicit focus on equity may increase inequity.

Among its highest priorities WHO should intensify its work to get equity higher up on the agendas of international organizations, governments, donors, and professional organizations. The capacity of governments to routinely monitor equity in health and health care need to be strengthened through suggesting options for simple yet valid approaches to ongoing policy-oriented monitoring of equity, using existing data sources from all relevant sectors and simple methods of analysis and presentation. Vital statistics capacity should be strengthened by incorporating socio-economic and geographic information as well as improving data quality, using census data in health equity assessments and population-based data from other key sectors.

WHO should reorientate itself to equity, and to the intersectoral cooperation required to achieve it. The Task Force on Equity in Health and Health Care should look into WHO programmes and the extent of their equity concerns. The Task Force should expand its membership to other international organizations, e.g. ILO, UNICEF, UNESCO. Similar mechanisms need to be established at regional and country levels.

INTRODUCTION

The challenge of promoting equity in health and health care is the major theme of the Equity Initiative launched by the World Health Organization with Sida support in 1995. One of the strategies adopted to pursue equity has been the identification of appropriate indicators and data sources to monitor equity, by using information on patterns and trends in key indicators to influence the policy process to achieve greater equity.

To further advance this work, the Meeting on Policy-Oriented Monitoring of Equity in Health and Health Care was convened from 29 September to 3 October 1997 at WHO headquarters in Geneva. It was co-organized by WHO, the Council for International Organizations of Medical Sciences (CIOMS) and the Non-Governmental Forum for Health. Participants represented Ministries of Health, universities, research institutions, non-governmental organizations, donors and WHO regional and country offices, with office-bearers appointed from this broad range of interested parties (Annex 1).

This technical meeting was designed to assist WHO in developing the next steps forward in this major initiative focused on achieving greater equity in health and health care. Although the primary concern of the meeting was policy-oriented monitoring, it was intended that this be seen in the context of the broader range of activities proposed by the initiative, which include policy development, implementation and advocacy.

In opening the meeting, Dr Hiroshi Nakajima, Director-General of WHO, stated that equity is a value that governments subscribe to, but do not always make explicit in their policies. The importance of emphasizing this value is that it is often overlooked in today's attempts to tackle the financial problems of health care. Health systems are in turmoil, partly because of severe economic difficulties in some parts of the world. Ministries in rich and poor countries alike have responded to the current pressure by introducing health sector reforms that are market-friendly and encourage competition. Such mechanisms may generate revenue for health, but may increase inequities. The overall gains in health that have occurred around the world are being overshadowed by increasing disparities between rich and poor. The number of people living in absolute poverty now comprises one fifth of the global population, or 1.3 billion people. In health and health care the gap is widening between rural and urban areas, with resources concentrated in the cities. Within the same country, life expectancy and infant mortality rates may vary enormously between regions, and often over 80 % of public health expenditures benefit less than 40% of the population.

Such inequities are both unnecessary and unjust. It is the responsibility of governments to ensure that adequate health care is accessible to whole populations, since market forces alone will not do this. The need for strengthened capacity to monitor health care for equity at both central and local level should be clearly recognized and indicators for monitoring must be carefully chosen. Ministries of Health must take the lead, not only in guiding the health system itself but in mobilizing partners and influencing the policies and activities of other sectors that affect health.

Solidarity and human-centred development are important in improving equity: "utility" considerations have to be balanced against equity concerns.

The work of this meeting would provide valuable input into WHO's renewal of the Health For All policy and its work in supporting countries in their effort to reduce health inequities.

Dr Nakajima concluded by saying that there is no easy solution to the problem of how to avoid conflict between the principles of equity and the demands of economic sustainability in the health system, but that we should take advantage of the fact that many people around the world are beginning to speak out about equity and social justice. Strong political commitment to equity and stability is needed, and it is our responsibility to promote that commitment in every way we can.

Dr Tarimo, Director of the Division of Analysis, Research and Assessment, outlined the objectives of the meeting and introduced the Programme of Work which was approved by the meeting (Annex 2).

KEYNOTE SPEECH

Professor M. Marmot emphasized that strong scientific evidence shows that fundamental socioeconomic inequalities are the most important determinants of avoidable inequalities in health, with health care services playing a lesser role. The causes of these inequities must be investigated as a basis for defining remedial policies and action. The Whitehall Study (Marmot and Shipley, 1996) in the UK, which followed ten thousand civil servants for 25 years (divided into four categories - administrators, professional/executives, clerical workers and support staff) showed a higher risk of death from most diseases amongst those lowest in the hierarchy. Evidence from this and other studies also showed that the gradient *between* classes has increased over time. This gradient is not primarily due to material conditions such as inadequacies in housing, food or clothing, as there is little difference in access to these amenities across the social groupings, nor is it due only to "social drift". Professor Marmot pointed out results of a number of his own and other studies which helped throw some light on why this might be, and the determinants of inequities in health and health care in industrialized countries.

Socioeconomic factors often determine "lifestyles" and harmful behaviours - they should not be construed as freely "chosen". Health care and genetics influence health but their role is of much less significance than that of socioeconomic factors. Correlation between education and poverty is greater than 0.8 in the UK; thus education serves as a proxy for poverty. Home owners have lower mortality than tenants (Filakti and Fox, 1995).

Findings of the Head Start Programme (Schweinhart and Weikart, 1991) for poor pre-school children in the USA were of great interest, as this study indicated there were feasible interventions that resulted in greater health improvement amongst the intervention group than in the controls.

Several studies indicate that lack of control in the working environment, stress, solitude, unemployment and a sense of lack of control over one's life were associated with higher mortality and ill health. Measuring this "sense of control", as well as studying its association with income and health or well-being, is a challenge for future work.

In the discussion that followed this address, some futher points were made. Developing countries lack data comparable to the Whitehall study in UK, which has been a major resource for studying these issues in industrialized countries. The issue was raised of the importance of seeking to identify some equity indicators that could be meaningful across different countries, while at the same time recognizing that the meaning and consequences for action of any particular comparison between social groups could vary considerably in different socioeconomic and cultural environments. The difficulty of assessing pathways through which social or environmental stressors affect health was underlined. How might the influence of a given stressor associated with socioeconomic differences vary according to gender or other attributes? Measures traditionally used to describe inequities centre on mortality and morbidity. Measures assessing quality of life are essential for a complete picture.

The relationship between income and level of health is strongly positive for countries with Gross National Products (GNP) below US$5000 per capita, but not above that level. The "Global Health Chart" (Annex 3), shows the relationship between GNP and child survival up to 5 years/1000 live births in 177 countries. In addition, countries with similar levels of GNP often have different health achievements. Hungary, Costa Rica and South Africa, for example, had comparable GNPs, but Hungary had a low infant mortality rate (IMR) and low life expectancy, Costa Rica had a low IMR and high life expectancy, and South Africa had a high IMR and low life expectancy. Lessons learned in reaching better outcomes might be studied by others.

FUNDAMENTAL CONCEPTUAL ISSUES: DISCUSSION HIGHLIGHTS

The concept of equity

Precise definitions of equity are not available; as one participant remarked, consensus on equity had "eluded philosophers for at least 2500 years". However, it is possible to communicate meaningfully about equity with the following understanding: that health inequities exist when there are inequalities in health status, risk factors, or health service utilization between individuals or groups, that are unnecessary, avoidable and unfair. Inequalities by socioeconomic status, geographical location, gender, ethnicity, and race were most frequently discussed, but inequalities in health care (e.g. a lack of services for mental health) or in disease distribution (e.g. AIDS) were also differences that were likely to be unjustifiable (i.e. unnecessary, avoidable and unfair) and therefore inequitable.

It is important to discuss and better understand the range of different concepts pertaining to equity held by different people, and to clarify points of consensus and disagreement where possible. This understanding of points of disagreement as well as consensus is needed to permit the meaningful communication required for effective social action.

Equity and determinants of health

Equity in health requires equity in the distribution of the determinants of health, including, but not limited to, health services. European experience, for example, shows that even in relatively affluent nations that emphasize equity in access to health services, there are significant inequalities in health status that reflect more fundamental social inequalities in socioeconomic status,

education, working and living conditions. Reducing inequalities in health status to the point where we can judge them not to be avoidable or unfair would therefore require: (1) special steps in the health sector to compensate for inequalities in risk factors, that arise from other inequalities (socioeconomic, gender, etc); and (2) further efforts to reduce these other inequalities through intersectoral action. Inequity in the determinants of health is a problem in all regions and all countries.

Equity in health care

Equity in health care requires the consideration of need in resource allocation. Communities must be involved in decision-making about how to reduce inequities; this requires that the decision-making process about health care resource allocation must be transparent and publicly accountable.

This view of equity implies that the WHO effort will require continuing examination as it evolves. If inequalities in health status are in part caused by broader social inequalities, then judgments about the fairness of those social inequalities will affect judgments about whether certain inequalities in health status are inequitable. Different countries may form different judgments about the unfairness or avoidability of these underlying inequalities. There will also be disagreements within countries that make reforms aimed at reducing these inequalities politically sensitive. However, monitoring the inequalities is an essential starting point to generate productive discussion on how to reduce them. WHO's technical assistance efforts must take into consideration these areas of potential disagreement between and within countries. Discussions of such fundamental disagreements might be better facilitated at the regional rather than global level. This was seen as an additional reason to support regional efforts to share information about successful and unsuccessful programmes and reforms aimed at reducing inequity.

Equity and globalization

Rapid changes in systems, especially the privatization and down-sizing of government programmes in response to global marketization, and to the specific demands of donors such as the World Bank, will make traditional efforts within health ministries more difficult and will call for greater intersectoral planning. Leaders in the social sectors affecting health need a clear understanding of how, in the absence of an explicit focus on equity, pursuing short-term economic growth has often increased inequity. They also need clear information on how promoting equity may in many instances promote economic growth, especially in the intermediate and long run. However they also need to be able to be effective advocates for greater equity, even when evidence of short-term overall economic gain is lacking. This requires clarity and consensus that the moral concern should not be submerged in the economic. Support is needed to ensure adequate opportunities for leaders at various levels to discuss the difficult issues with their counterparts in other countries. Some WHO Regional Offices have already begun to address this need to some extent. Support for this type of activity could help leaders at various levels to more effectively advocate for the adoption of equity-oriented programmes.

Also in light of global pressures for greater efficiency, leaders need to have up-to-date information on which programmatic approaches work best, and which are unproductive or counterproductive. Sharing this type of information is important because it also addresses another

concern expressed at the conference. Targets will be judged unrealistic if countries do not have a clear idea of what programmes will move most efficiently towards achieving them. Realistic target-setting requires a knowledge of underlying mechanisms, and programme proposals that address them. It appears to be important to document and analyse experiences - successful as well as unsuccessful - and efforts to achieve greater equity in developing countries under current economic and political conditions. Forums are needed to distill generalisable insights.

SHARING EXPERIENCES IN MONITORING OF EQUITY:

Monitoring of equity at the district and local level

Four presentations were made, the first outlining the **"healthy villages" programme in Syria and Jordan**.The objective of the programme is to improve human development and the quality of life of villages through integrated social development, with health as the entry point. A critical component of the programme is the focus on the empowerment of people, building community partnership. A "bottom-up" strategy has been adopted, giving an opportunity for people to decide on their needs and develop appropriate programmes to improve their health. The process is supported by an intersectoral technical team which trains community leaders and provides technical inputs to the planning and implementation of activities. Indicators for the programme are identified and decided on by the communities themselves. These include determinants of equity used in the programme including those about availability and use of services, geographic differences and life-style. For example, communities keep a record of numbers of smokers and observe trends. Communities need to monitor issues that are important to them: the number of facilities in a territory is not necessarily meaningful to people, but rather the type and quality of services offered.

The second presentation outlined work being carried out under the **Department of Social and Preventive Medicine of the State University of Campinas Medical School, and the Health Secretary of the City of Campinas, Brazil** (population 1 million). In this project the population has been divided into four social-economic strata based on the following variables: percentage of illiterate dwellers between 15-65 years of age, percentage of heads of family with 11 or more years of schooling, and percentage of heads of family with an income less than $240. It was found that while age adjusted death rates from infectious diseases, except AIDS, were similar for the four groups, the rate for AIDS and homicides was much higher in group 4 than in the other groups, especially for males. Suicide rates were similiar across all groups but motor accidents were much higher in group 4. Overall, accidents and violence were the leading causes of death for males in Group 4, whereas in Group 1, it was cardiovascular disease.

The third presentation summarised experience with **community health information systems in Pakistan**. The work centred around primary health care programmes in poor urban communities in which the IMR had declined from 126 to 64 between 1988 and 1993, at which point it levelled out.The reasons for this stagnation were not understood. A case-control study was undertaken to determine risk factors that could be used for better targetting of community-based interventions. The risk factors identified by the case control study are now being incorporated into a household risk factor index that can be applied in community programmes.

The last presentation focused on the use of **regional and local indicators of socioeconomic circumstances and health care in Chile** as a basis for analyzing equity. Health care reforms in Chile have been "market oriented", and deregulation of the public health system in general has been carried out.The data provided showed that infant mortality rates were related to avoidable risk factors, particularly poverty. Although general physicians were fairly distributed, specialists were concentrated in a few areas. On the whole, it was concluded that poor areas with high mortality had poor services with fewer resources provided.

The main messages from the discussion were that:

- Disaggregated data is needed at all levels, including local and district levels, to allow for the identification of inequities.
- Communities should participate more in planning health activities, thus creating ownership of efforts and commitment to ensuring their success.
- Data to be collected must be carefully selected and defined, since there are costs involved.
- Policy makers and health workers in general need orientation to become sensitive to inequities in health and health care in their daily work.
- Monitoring of equity has so far been confined to the public sector and there is little information on the situation in the private sector.
- International support/aid often benefits health system providers, in terms of assisting with technology and support, but is of little benefit in improving equity in health and health care at the local level, as it lacks this focus.

Using existing data sources to assess equity in health and health care in developing countries

A presentation based on the first stage of **WHO-supported equity work in Sri Lanka** gave three examples of indicators, and ways of displaying the relevant comparisons using those indicators, that the team there had found particularly useful for assessing equity. The team had restricted itself to the use of three standard indicators from available data sources: infant mortality; per capita distribution of qualified medical officers overall and by specialty; and per capita expenditures on medical supplies. In each case, comparisons were made between provinces, and then between districts within each province. Comparisons were displayed graphically and using maps, calling people's attention to each province, but without requiring special mapping software. Time trend data were displayed via line graphs. For each indicator, the most recent cross-sectional picture was presented, followed by a time trend. While showing the picture of inequalities does not explain the causes, it has been useful in stimulating discussion by the stakeholders at the appropriate level, who needed to discuss: (1) does the situation (current pattern and time trends) appear as equitable as it could be? and (2) if not, what could be done in the short, intermediate, and long term to make the situation more equitable?

Secondly, **possible uses of the living standard measurement survey (LSMS) data from Zambia** was presented. This was used to investigate equity of access to health services, the results showing a disproportionate use of public health services by the more economically advantaged segments of the population. Lessons learned from the experience included the importance of clarifying the information actually needed by a Ministry of Health before funding such a study (either using existing data or collecting new data), and then building on linkages

between policy-oriented researchers based at a university, and the Ministry. Studies of use of church or NGO-funded mission hospitals has tended to show similar patterns, that is, disproportionate use by better-off segments of the population.

The use of **Demographic and Health Surveys (DHS) in Zambia,** with examples of the construction of composite indices of household socioeconomic circumstances was given. The DHS cannot be used at the district level because of the sampling frame, and it is relatively expensive to conduct. On the other hand, the LSMS lacks health information, while the DHS lacks income information but has indicators of female education. The possibilities for a coordinated effort from the sectors/agencies responsible for developing such data sources should be examined.

The **Pakistan National Health Examination Survey** was a further example presented. The survey had revealed large discrepancies between reported immunization coverage rates and actual immunization levels as reflected by ELISA testing of blood samples. The survey also revealed unexpectedly high prevalence of chronic diseases, including diabetes and hypertension, that had not previously been documented. From an equity perspective, it was questioned whether the expense involved in conducting periodic household examination surveys was justified in countries that did not yet have adequate vital registration and census systems, since the latter elements are essential for monitoring health equity. Others argued that health interview surveys were essential and needed to be strengthened. At least as a one-time or occasional effort, an examination survey could reveal issues with regard to equity that might not be captured by other less expensive approaches, and that the information gained might be used to design less expensive surveillance approaches that could be applied with more frequency. In many countries, funds from several different donors are often used to conduct several separate disease-specific examination surveys, and consolidation into a single survey could be more efficient.

During the discussion of use of existing data, there was general agreement on the following:

- Existing data could and should be used more, but changes are needed in data elements and data collection methods as well as in analysis and presentation of routine data.
- Vital registration (of births and deaths) is a major source of existing data that is critical for assessing equity. Vital registration is required by most governments but is often incomplete or of very poor quality. One of the main reasons for poor quality is the fact that the data are hardly used at all; those who collect it pass it on and receive no feedback. The quality of vital registration could be improved considerably and efficiently by analyzing the data close to the community and providing feedback for relevant action.
- Routine service data might be used in several ways, (e.g. data on vaccinations, antenatal care, and family planning services) to assess equity. Such data might not adequately reflect inequities unless they were population based.

Challenges in monitoring equity in industrialized countries

Throughout **Europe**, the chance of dying prematurely is greater among the manual than the professional classes, but there is inter-country variation in the magnitude of the disparities. Socioeconomic disparities in mortality ratios appear to be increasing over time in all countries of

Europe. A study (Kunst, 1997) found no simple relationship between degree of income inequality as reflected in the Gini coefficient, and mortality risk ratios. Income inequality interacts in complex ways with other factors to produce health inequalities, and the association should not be oversimplified. Other factors include the socioeconomic distribution of risk factors such as smoking and protective dietary practices. Particular gaps were noted in research demonstrating effective interventions to reduce inequity.

A presentation from the **United States** showed that a significant portion of the national population now lives in inner cities, where socioeconomic conditions are poor and mortality rates are disproportionately high (despite the availability of sophisticated health services). An analysis of patterns indicated that economic and social factors rather than health services play the determinant roles. Both absolute levels of income or wealth and relative disparities appear to be involved. Wealth or assets are more important than income, because wealth reflects long-term effects (resources accumulated and held over time, e.g., family inheritance) whereas income may fluctuate. Inequalities in assets can be used to predict death rates. Education is a good socioeconomic proxy because it tends to reflect cumulative effects of socioeconomic deprivation. Residential segregation of racial and ethnic subgroups also appears to be a significant factor in itself, but this has selective adverse effects on different groups: "Whites" living in residentially segregated "White" areas do not suffer from ill health effects of residential segregation, but Blacks and Hispanics do dramatically.

A presentation on **Lithuania** discussed the difficulties of using existing data to assess the relationship between income inequality and health status, for example, due to the long lag time for risk factors for chronic diseases to manifest their effects. The reason that income inequality matters is poorly understood. Time trends are crucial, because one may arrive at misleading conclusions regarding policy if they are based only on cross-sectional data.
The use of the term "equity" in itself is a sensitive issue in many parts of the world, where the term is associated with old regimes that were unpopular and that are perceived by some as having paid lip-service to equity.

Discussion of the presentations brought out many issues, including the following:

- Ecologic studies that take into account the complex interactions between individual-level and community-level factors were considered to be important, especially in assessing equity. There certainly was an "ecologic fallacy", but that there also was such a thing as an "ecologic advantage", and an "individual fallacy" that epidemiologists were only just beginning to recognize[1].
- It was important to understand how, for example, Sri Lanka has shown such improvement in social and health indicators despite poverty, and to understand why the poverty itself has not decreased despite improvement in overall social and health indicators.

[1] "Ecologic fallacy" refers to assuming erroneously that all individuals in a given area share a given characteristic that applies on average to that area. "Individual fallacy" refers to failing to consider important effects on an individual of living or working in a given area, if area characteristics are not considered.

Experiences with measuring poverty and identifying areas of greatest need

Experiences from **Bangladesh** were presented, particularly a concern with the "poorest of the poor". It was pointed out that in Bangladesh, the "poor" is not just one group of society, but that there is a gap between the "moderately poor" and the poorest. Measuring income levels may not be the most sensitive indicator for identifying the poorest, and there is a need for other indicators. Examples could be group characteristics, for example, land ownership, housing, or occupation. Finding socioeconomic indicators that are both sensitive and specific should be a high priority for policy-makers concerned with equity.

The meeting continued with a focus on **Sri Lanka** where experience with anti-poverty programmes was shared. It was pointed out that information is needed at all levels of administration. Suggested indicators for measuring deprivation at household level were given. These included:

- Income (e.g. distance from consumption poverty line)
- Health (e.g. child mortality)
- Nutrition (e.g. low birth weight)
- Education (e.g. head of household - education level)
- Fertility (e.g. size of household)
- Occupation (e.g. unskilled labour)
- Living conditions (e.g. housing)

The process of identification of the most vulnerable groups was outlined. It included identification by geographic area, level of administration, natural endowment and infrastructure. The data sources used for identification differed according to each level of administration. It was concluded that different groups suffer from different forms of deprivation. Those who are in greatest need are those in a state in which "income poverty" and other forms of deprivation coexist. For identification of the poorest groups, community based information systems and monitoring systems are needed as an integral part of a national system for monitoring poverty and equity.

A presentation was made on the use of **Geographic Information Systems (GIS)** for assessing equity in health and health care in developing countries. Examples were given of how relevant information, disaggregated according to relatively small geographic areas that were administratively and socially meaningful, could be displayed graphically on maps. The GIS is essentially a tool for displaying information meaningfully to make small area comparisons; it is not a data source in itself. The GIS is only as good as the data that are fed into it. It is important to consider the type and level of a health care facility, not just the number of facilities. By using GIS the geographic distribution of a particular disease (e.g., guinea-worm), can be seen along with the distribution of schools, health care facilities, safe water and sanitation, and transportation. The GIS is a very powerful tool since it allows policy-makers to assess location and magnitude of a problem. It also provokes action-oriented management and planning and shows population needs in relation to resources.

Experiences on the **Equity in Health Approach from Chile** were shared and it was shown how identification of health needs in deprived areas or pockets of poor populations had been undertaken. Health services originally meant for the poorest groups of society, e.g. mission hospitals have become services for the middle class since they are considered of a better quality than the public health services. It was emphasised that the poor have an important role to play themselves in identifying inequities, as their perception of poverty may differ from the non-poor's perception.

EQUITY TARGETS AND INDICATORS:

Setting the framework: equity targets and criteria for selecting indicators

Experience with setting and trying to achieve equity targets in the European region was presented. As an example, one of the European targets was given: "By the Year 2000, the differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups." (WHO, 1985). Monitoring of progress on this target is based on monitoring indicators (including reduction of disease and disablement, elimination of specific diseases, life expectancy etc), disaggregated by age, sex, geographic location, and socioeconomic categories.

The process to date has been slow, and "success stories" of achieving equity targets are not available; however, setting targets has seemed to be an effective means of getting equity on the policy agenda, in concrete terms.

A framework for selecting indicators was developed aimed at policy-oriented monitoring of equity in health and health care. Although it was acknowledged that monitoring equity is sorely needed in all countries, the focus at this meeting was on the needs of developing countries. The approach prioritizes the use of standard indicators already widely used for monitoring populations in developing countries, as an essential first step. The goal was to select standard indicators of health and health care which, when appropriate comparisons among different social groups were made using these indicators, seemed particularly useful to assess equity in health and health care for policy purposes. The task was not to invent new indicators, but to select from among standard indicators, those most useful for making appropriate comparisons. It was agreed that this meeting would focus on indicators of socioeconomic, geographic, and gender equity, although there are other important dimensions of inequity as well (e.g., race or ethnic group, age, mental illness, physical disabilities or other social stigmata).

Four criteria for selecting indicators useful for policy-oriented monitoring of equity in health and health care were generally endorsed:

Table 1:

Key Criteria in Selecting Indicators for Monitoring Equity:
1: Relevance to policy on equity
2: Accessibility of disaggregated data
3: Simplicity
4: Standard scientific and ethical criteria

1: Relevance to policy on equity:

Indicators should reflect relevance to the appropriate stakeholders, including the public, at the appropriate geographic level. Public transparency and ownership of the targets is necessary to ensure accountability, given the fact that trying to achieve equity often means swimming against the tide of the most powerful prevailing forces. The indicator should be useful for setting a measurable equity target (see below), using targets as part of a political strategy. The target should focus on an issue where some gains could be made (although there was no consensus about whether targets should be set unrealistically high in order to provide inspiration, or should be based on assessments of attainable objectives given realistic assessment of likely resources in the specified time frame). The public and policy-makers would pay attention to only a very limited number of indicators at a time, so the process had to be highly selective, identifying the best among relevant options.

2: Accessibility of disaggregated data:

Existing data sources, which permitted the necessary disaggregation of data, or that were available using low-cost methods (for example, rapid assessment methods already tested at the appropriate geographic level), were most appropriate. The affordability of repeated measurements over time (i.e. monitoring) was part of this consideration. Data sources outside the health sector should be considered and used more by the health care sector. Unnecessary duplication of data collection efforts across different health-related sectors as well as within the health sector should be avoided, and there is a need for consolidation and coordination. There are many limitations to existing/accessible data, and improvements are needed. However, not enough use is currently being made of this data to examine questions of equity, and meaningful comparisons (for policy purposes) could be made using standard indicators. More emphasis needs to be placed on guiding decision-makers to make the appropriate comparisons of indicators of health and health care, broken down by measures of poverty/income, geographic markers, education, gender, and ethnic distribution. Frameworks to be recommended by WHO for selecting indicators should give more explicit emphasis to this consideration.

3: **Simplicity,** both of data collection and of interpretation - the latter to permit public transparency and hence accountability to the public by policy-makers - is essential. It is important that a very limited number of indicators are selected for presentation, and the information is clearly and appropriately presented to the intended audience.

4: **Standard scientific and ethical criteria.** Only indicators that meet standard scientific and ethical criteria should be considered.[2]

Different ways of formulating an equity target with a given indicator were discussed. Formulating an **equity target** is probably more important than which specific indicator is selected, as it is the target that is explicit about (1) which domains are to be compared, and (2) the level of acceptable difference aimed for. (Domains include class, sex, geography, for example).

It was acknowledged that targets need to be set by relevant stakeholders at the appropriate level, considering available resources, priorities, and preferred strategies; but that it would be helpful if WHO could provide some examples of different ways an equity target might be formulated, which could suggest appropriate options to people in different circumstances. Using child mortality rates, the following examples illustrate what is meant by an equity target, as contrasted with a generic target that does not address issues of equity:

- **A generic target**: By the year ____, reduce child mortality to x%.

- **Contrasted with possible equity targets**, e.g.:

  Domain
  (a) By the year _____, reduce child mortality to x % overall, and reduce it to no more than y% among the specified domains/subgroups; or

  Class
  (b) By the year _____, reduce child mortality to x% overall, and reduce the disparities in child mortality between the highest and lowest income quintiles by z%; or

  Geography
  (c) By the year ____, reduce child mortality to x% overall in this province, and reduce the disparities among the districts within the province by y%; or

  Sex
  (d) By the year _____, reduce child stunting to x% overall, and reduce the disparity in stunting rates between girls and boys by y%.

There was disagreement about whether equity targets should focus on the most vulnerable (the poorest of the poor), or on vulnerable groups (the poor) overall.

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[2] see International Guidelines for Ethical Review of Epidemiological Studies, CIOMS 1991

Recommended indicators in four essential categories

There is a need for indicators that reflect differences in the populations to be compared, for example, socioeconomic and geographic groups. However, this segment of the meeting focused on indicators of health and health care that would be helpful to compare between different social groups, rather than on indicators to define the social groups themselves.

Based on the working groups and discussion in plenary, the following indicators of health and health care were recommended for use at different geographic levels. Recommendations of WHO programmes should be followed wherever these existed, and the WHO Catalogue of Indicators *(WHO, 1996)* was an important resource. Few of the recommended measures are currently possible to monitor in appropriately disaggregated data at the district and especially sub-district levels, but affordable methods exist to do this and the development of this capacity needs to be a priority.

Indicators selected for monitoring should be sensitive to the epidemiologic situation in a country, as well as accessible in the country's data sources. Thus, middle or higher-income countries might find it advisable and feasible to include indicators of chronic/degenerative diseases and disability (that affect quality of life but may not be reflected adequately in life expectancy data), while such indicators might not be realistic in many developing countries, even some with aging populations, at least until a basic vital registration capacity is developed.

Indicators of determinants of health (apart from health care) recommended for which data sources could be identified:

- **prevalence and level of poverty** (measured by the census)
- **educational level** (from census);
- **safe water coverage** (from census or sanitation sector records); and
- **adequate sanitation coverage** (from census or sanitation sector records).

Other indicators of determinants of health apart from health care that were considered, but without identifying data sources, included community partnerships and adequate housing.
The health sector needs to include the monitoring of inequities in at least a few of the basic, most powerful determinants of health apart from health care, in any monitoring of equity in health.

Indicators of health status:

The following two indicators were endorsed as among the highest priorities:

- **Child (under-5 years) mortality rate**
- **Prevalence of child stunting**

Routine information systems (vital statistics, household nutrition surveys) to monitor these variables in an appropriately disaggregated fashion must be strengthened. Comparisons made using indicators of children's health status appeared considerably more sensitive to socioeconomic differentials than did indicators of adult health status. Equity targets should focus on child health not because adult health issues are unimportant, but because investments in the health of children

have a long-term impact on equity. Low numbers of child deaths could make CMR an unreliable measure in small populations, but where rates were thought unreliable, child deaths could be monitored as sentinel events.

In addition, maternal mortality was recommended as highly relevant; however, in most cases it would be unreliable to look for changes in maternal mortality at the local level or over a short period of time, although it could at least be monitored as a sentinel event.

No single indicator (or even a group of indicators) and no single method of analysis can adequately describe a situation, but it is advisable to concentrate on a limited number of specific indicators - e.g., growth stunting, child mortality rate, or maternal mortality ratio - disaggregated by socieoconomic status or geographical location. This is because these are particularly sensitive measures of gaps in health status that are generally judged to be avoidable, unnecessary, and unfair.

Other indicators of health status recommended included: incidence of relevant (that is, pandemic or endemic) infectious diseases, such as malaria, TB, HIV, guinea-worm (measured via sentinel surveillance systems already in place through WHO programmes); injury rates as a proxy for violence (or specifically rates of domestic violence), without being able to specify a data source for either; IMR (in addition to CMR, the latter being preferred because it was less likely than IMR or neonatal mortality rates to be limited by under-reporting among disadvantaged groups as measured via vital registries); age- and gender-specific life expectancy, and age-specific adult mortality rates, as measured in vital registries.

Measures of the prevalence of hypertension, obesity, and smoking should be among health status measures used. However, the measurement of hypertension and obesity requires household-based physical examinations (as facility-based data is not acceptable for any of the measures), which would be far more expensive than interview surveys. A less expensive approach could be periodic household examinations conducted by health centre staff in randomly selected clusters of homes in their catchment areas. There is a need to ensure adequate vital registration and census data, and to utilise existing sentinel surveillance systems, before investing in expensive new modes of data collection that could divert attention and resources from the basics. Vital registration must be made adequate for the purpose of assessing equity, which would involve including some proxy measures of socioeconomic status as well as geographic markers.

Indicators of health care resource allocation at national and sub-national levels, but not at international levels, were discussed. This indicator refers to how resources actually are allocated, not how they should be allocated. The actual allocation of resources should be described and its fairness assessed in relation to indicators of need, that is, health risks and health status. Some countries have been developing formulae to systematically estimate needs of subnational regions, to guide health care resource allocation decisions.

At the district level:

- **per capita distribution of qualified personnel** and
- **per capita distribution of services facilities at primary, secondary, tertiary and quaternary levels** were recommended.

At the national and provincial levels:

- **per capita distribution of qualified personnel** and
- **per capita distribution of total health expenditures on personnel and supplies, as well as facilities,** were recommended.

Merely counting personnel or facilities per population, without differentiating the type or level, was insufficient to assess equity. The type/level/quality of resources allocated needs to be reflected in comparisons for assessing equity (e.g., fully qualified doctors per population, not just health care personnel per population; tertiary-care facilities per population, not just facilities per population, which could include facilities with highly limited services).

Indicators of health care utilization were also discussed at national and sub-national levels only. The number of indicators that is ideal to use varies with the intended audience, for example, only 2 or 3 indicators of health care utilization should be used with policy-makers; 4 to 6 might be used with decision-makers; and 10 or more could be used with health professionals.

The following indicators of health care utilization were recommended:

- **immunization coverage** of children by sex/class, measured by population-based surveillance data. There is a need for periodic verification of immunization levels through laboratory tests of antibody levels on a subsample of the population, to ensure quality control, but large-scale laboratory-examination surveys were not justified to monitor immunization coverage on a routine basis.
- **antenatal care coverage** (measured by interview surveys, including measures of content, timing, and numbers of visits according to national norms).
- **% of births attended by a qualified attendant** (per interview surveys)
- **current use of contraception** (per interview surveys).
- In addition, **TB treatment completion rates** were suggested as an option at the local level, and **cervical cancer screening rates** at the national/provincial level, but sustainable data sources were not identified.

Utilization of public health services is often inequitable, with the higher-quality, more expensive services disproportionately used by more privileged segments of society. This issue needs to be addressed in the monitoring of equity in health care. For this reason, population-based data sources are essential in assessing equity in health care utilization, as in all the indicator categories. Currently, routine public health information system data are generally facility-based or programme-based, and do not reflect segments of the population not served by the public health care system. Many opportunities to make better use of information available from other sectors and from the outreach programmes of the health care sector are missed, that could supplement facility-based information from routine health data. Routine health information systems need to be strengthened so that they are adequate for assessing equity. Investment in expensive special surveys often diverts attention and resources away from building an adequate ongoing routine system.

Table 2: Key indicators for monitoring equity in health and health care

Indicator categories	Indicators measuring differences between population groups
1: Health determinants indicators:	Prevalence and level of poverty Educational levels Adequate sanitation and safe water coverage
2: Health status indicators:	Under 5-year child mortality rate Prevalence of child stunting *Recommended additional indicators*: Maternal mortality ratio; life expectancy at birth; incidence/prevalence of relevant infectious diseases; infant mortality rate and 1-4 year old mortality rate expressed separately
3: Health care resource allocation indicators:	Per capita distribution of qualified personnel in selected categories. Per capita distribution of service facilities at primary, secondary, tertiary and quaternary levels. Per capita distribution of total health expenditures on personnel and supplies, as well as facilities.
4: Health care utilization indicators:	Immunisation coverage Antenatal coverage % of births attended by a qualified attendant Current use of contraception

TOWARDS THE 21ST CENTURY: EQUITY IN THE RENEWAL OF "HEALTH FOR ALL":

The session was opened by Dr F. Antezana, Deputy Director-General of WHO. Dr Antezana stressed the fact that equity underpins the concept of Health For All (HFA) and is fundamentally a call for social justice. Equity should be analysed in all its aspects - cultural, human and spiritual, and focus should not be restricted to the economic dimension.

The new policy ***Health for All in the 21st Century***: The Alma Ata Conference did not change WHO's constitution, but resulted in the launch of HFA with primary health care (PHC) as the strategy by which to achieve it. There is now a demand for a revitalized commitment to equity, due to the fact that there are increasing numbers of people living in absolute poverty, with increasing gaps between rich and poor, serious health effects of poverty, environmental risks and an uneven distribution of the benefits of globalization.

The realization of HFA in the 21st Century will build on an evidence base from both research and experiences. There is a need for intersectoral action at national and local levels to target inequalities and the establishment of precise indicators to measure inequities. The new policy introduces equity-oriented indicators, in particular, child health and child growth. In order to achieve equity, it should be made an explicit criterion for priority-setting. Health systems have to act and ensure universal access to adequate quality care and adopt life-span approaches which

give priorities to prevention and health promotion. Equity should be ensured at each stage of the life-cycle.The presence of a growing proportion of elderly persons in almost every country requires a re-thinking of strategies, and focusing on equity for children seems to have the highest yield for the entire society, including adults of all ages.

Legislative approaches, such as in the area of health promotion and environmental health are essential. Some believe that the poor or the poorest should be explicitly and directly targeted, particularly through maternal and child health stategies. However, others believe that the focus should be across the full spectrum of society, that is, the broader issue of inequalities and how they affect an entire society.

At the global level, action for equity demands global surveillance of equity. The research priorities need to be readdressed and the resources redistributed. Further, international technical cooperation favouring people in greatest need should be intensified. Finally, transnational actions preventing marginalization as a result of globalization should be strengthened.

During the following discussion, there was strong support for the draft policy document and for it placing emphasis on equity. A number of suggestions on how it could be strengthened were given. Equity should be made more explicit, particularly in the "action" part of the document. The title of the document was discussed and because of its importance, it was suggested that equity should also be present in the title, for example: ***Equity in Health - a challenge for the 21st Century***. This would emphasize that Health For All" means equity. The definition of health and the re-use of the concept of "Health-For-All" were raised. HFA should be redefined, to make it more meaningful to people. The differences between the values that are driving economic development and those for health should be made more explicit. The policy should have a fixed target date: "in the 21st Century" is too vague a timeframe.

The Policy Document language should be simplified - its present complexity, with many layers of objectives and goals, was emphasized.

The role of civil society needs to be made more explicit, with people as partners, as recognised in the Alma Ata Conference. Civil society has the capacity to cope with health needs and demands in national and local situations and needs to be strengthened. Ministries of Health were not necessarily seen as being the most effective institutions in promoting health. The need for an intersectoral approach to health was stressed and, as health is central to development, this should be emphasized more strongly, implying organizational changes for WHO itself and for ministries of health. Other sectors need to be invited to participate in health policy development, and the ways in which the health sector can contribute to other sectors need more attention.

Organizations such as UNICEF, the World Bank, and Human Rights movements all regard equity somewhat differently. Linkages are important in order to ensure consistency in the work for equity in health and health care. However, the important role of WHO was acknowledged. WHO has a moral voice, and should speak out regarding inequities in health and health care. This would also help WHO to regain its standing as the world's health equity conscience, even at the risk of upsetting certain interests.

There is a need for an NGO-based "Global Health Watch" that complements WHO's work[3]. The Watch should work towards closing the inequitable gaps at all levels and monitor the implementation of HFA in the 21st Century as well as relevant UN Conventions adopted by countries. The policy document should build its work on United Nations Conventions and should reconfirm the relevant UN summits, e.g. the Vienna Conference of Human Rights and the Social Summit in Copenhagen.

The strategy has three foci: provision, means and the recipient, but the last tends to be neglected. The meeting saw it as important to look at lifestyles, education, and attributes of human beings, both as reflections of fundamental inequities and as risk factors that could need to be altered to achieve greater equity in health and health care. Problems of mental health seem to be particularly neglected.

ADVANCING EQUITY: STRATEGIES FOR WHO

Obstacles to equity, as a basis for considering strategies

- As a basis for recommending strategies, different types of obstacles to equity in health and health care were identified. **Lack of clarity on the concept of equity** itself, and equity in health in particular, are obstacles. Failure to link equity in health and overall development was seen as a crucial obstacle. The contribution of health equity to overall growth and development should be highlighted when possible, but ethical issues should not be made secondary. The fundamental association of wealth and power in societies was mentioned and the current emphases on market forces, privatization, and government "down-sizing" were repeatedly identified as major obstacles.

- The **role of policy-makers** is important. There is a lack of awareness among policy-makers on the problems of inequities, as well as of the potential impact of more equitable distribution of resources. Coordination among different sectors is essential, and the health sector could benefit from lessons learned in other sectors.

- **Lack of useful data** and lack of analysis of existing data is problematic. Affordable information systems which can produce reliable and valid data for use in the policy-making process are essential to guide change. However, analysis of already existing data should be a first step even before collecting new data. In general, more communication and information are needed not only on inequities, but also on how the message is best communicated. WHO should ensure the dissemination of intellectual innovations and success stories.

- The **management of the health sector** is often an obstacle. There is a demand to provide management tools and strategies for improved coordination within the health sector in order to decrease inequities in health. Structural obstacles are also important, e.g. the

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[3]The Geneva-based NGO Forum for Health is currently planning the initial stages of the "Global Health Watch".

fragmentation of social insurance that excludes some people, and private insurance which excludes many.

- **Equity is a missing component in medical/health worker education and training**. Introduction of the concept of equity into the education system and an increased awareness and potential advocacy for equity could be secured. The lack of awareness, not only among professional groups but in general across society, is another major hurdle. Even more importantly, the general **acceptance of inequities** is probably the hardest obstacle of all and the reason why well-presented information on inequities is extremely critical. This information will play a crucial role in the mobilization and involvement of people. The need to develop different strategies for different stakeholders - policy-makers, professionals and the public - is essential for "selling the product".

- Some **global issues** including the roles of private companies, e.g., the pharmaceutical industry and conditionalities of donor policies were highlighted. The potential impact of World Trade Organization (WTO) agreements, and the prescriptive nature of World Bank policies, on health is an area of concern.

Focusing on solutions

Moving forward requires a change in focus, from just seeing obstacles to focusing on positive solutions. Which direction should be taken, in view of the different ideas of equity which are dependent on the country specific contexts?

Examples of current efforts of WHO: Examples of on-going work at the country, regional and global level were presented. At the country level, the experience in Zimbabwe was demonstrated as evolving strategies for equity in health started in 1981. The strategy is now entering its third phase and while there have been achievements in a number of areas, inequities remain. At the regional level experiences from AMRO were presented. The concept and context of health and human development in the Americas were reviewed together with the lines of action for public health, particularly as related to the new focus on measuring and monitoring equity. The relation of infant mortality rate to income levels and the increasing gap in relative ratios of infant mortality rate among the countries of the region to least IMR were noted. The way forward towards equity was outlined by sharing experiences and services through information and communication systems.

At the global level, information was provided on the **WHO/Sida initiative** on **Equity in Health and Health Care**. This three-pronged initiative has activities related to advocacy, strengthening linkage with other agencies and institutions and supporting research and development in selected countries. A presentation was made on the NGO perspective emphasizing the importance of building partnership among different agencies concerned with health especially given their changing roles. Strong pressures for structural adjustment and privatization were leading towards increased inequities. Even NGOs often were tilting provision of services towards the better off. A new kind of partnership amongst government and NGOs, particularly those that deal with multisectoral programmes, must be formed to rally around the need to serve the poorest. The issue of accountability of NGOs was raised.

Recommendations for WHO's next efforts

A number of specific strategies for future WHO work were identified:

- WHO's strategy on equity in health has to **focus on health status and health risks**, not only on access to health care. Evidence is strong that inequalities in health cannot be significantly reduced without tackling basic social and economic inequalities themselves. WHO should issue a **"state of the art" document on equity in health and health care, including "success stories"**. WHO also needs to take advantage of relevant work that other agencies are doing, and avoid duplicating efforts.

- **WHO needs to be bolder**, and speak out on controversial issues such as privatization, unhealthy industries, unhealthy trades (selling arms) and unhealthy businesses (for example, slavery and prostitution). Progress on equity will not be achieved by a "business as usual" approach, given the formidable political obstacles to equity. WHO needs to state clearly that equity is important for ethical reasons, not only for pragmatic reasons, while at the same time disseminating evidence of situations in which greater equity has led to greater economic development. In addition, WHO should disseminate evidence of where pursuing economic growth without a systematic and explicit focus on equity may increase inequity.

Among its highest priorities WHO should intensify its work to get equity higher up on the agendas of international organizations (including WHO), governments, donors, and professional organizations. To achieve this WHO should:

- Work with governments to develop a mechanism for systematic assessment of progress toward equity in health and health care within countries on the basis of specific targets set by the individual country. The assessments should be conducted at regular intervals, e.g., every two years, and be as "objective" as possible, similar to OECD reports. WHO needs to provide leadership and support for capacity development of appropriate data systems that collect, analyse, and report information to guide policy on equity.

- Feature equity at the 50th Anniversary of WHO. The 1998 World Health Assembly and the launching of the Policy for Health for All in the 21st Century can be used for the promotion of equity. Sub-regional and regional meetings might build toward this.

- Encourage people to disseminate material focusing on equity to the media, including scientific journals, bulletins and fora of professional associations.

- Encourage the development and monitoring of equity targets at all levels (local, provincial, national, regional, global). This will require societies to discuss among themselves different concepts of equity that have operational implications.

- Provide tools and instruments for the conduct of assessments of equity in health and health care, emphasizing participatory action-oriented approaches.

- Provide fora to encourage policy-makers to use equity as a routine criterion in decision-making, and to use information on equity to guide resource allocation decisions. Passage or implementation of legislation could be one of the necessary changes.

- Develop training materials for undergraduate, graduate and postgraduate students and advocate the incorporation of equity issues into medical curricula as well as in other educational fields, such as law.

WHO should assist in strengthening the capacity of governments to routinely monitor equity in health and health care. This could be done by:

- as an interim measure, suggesting options for simple yet valid approaches to ongoing policy-oriented monitoring of equity, using existing data sources from all relevant sectors and simple methods of analysis and presentation. WHO should complete and disseminate the work on indicators/targets discussed during this meeting. Existing data can be utilized far more than is the case now, but marked improvements are needed in data sources and how they are utilized.

- suggesting options for efficient strategies for improving ongoing information systems. Strengthening vital statistics capacity by incorporating socioeconomic and geographic information as well as improving data quality, using census data in health equity assessments and population-based data from other key sectors, and streamlining data collection systems were some suggestions. WHO should suggest ways to ensure that information collected locally is useful and easily accessible for decision-making at all levels.

- developing a network of policy-oriented national researchers with practical experience in using data to assess equity.

- intensifying work with partners to create fora for sharing successful experiences. However, WHO needs to recognize that Geneva-based NGOs may not be representative; criteria for selection of partners need to be systematic and transparent. WHO should strengthen the promotion of international collaboration in equity research, coordinate ongoing activities and function as a "clearing house" for sharing information, e.g. produce a newsletter, or create a homepage on the World Wide Web. The creation of an international forum on equity was also suggested.

WHO should reorientate itself to equity, and intersectoral cooperation, both at HQ and between HQ and the regions, should be strengthened. The Task Force on Equity in Health and Health Care should look into WHO programmes and the extent of their equity concerns. The Task Force should expand its membership to other international organizations, e.g., ILO, UNICEF, UNESCO. Similar mechanisms need to be established at regional and country levels. To enhance action, the Task Force should advocate the development of "cascading targets" which will enable action to be focused on short as well as long term work.

CONCLUDING COMMENTS

The meeting realised that these recommendations would be a great challenge to WHO. The Organization is being asked to become the world's conscience on equity in health and health care, but, given limited resources and being dependent on the good will of governments, how will this be carried out? It is essential for WHO to take an active leadership role on this issue because it is consistent with WHO's underlying mission, and because there is not another organization that is as strategically placed to do this. A number of participants commented that there was a sense at this meeting which was reminiscent of the awareness of the potential for change and urgency of movement around the time of Alma-Ata, and that this momentum should not be lost.

MEETING ON POLICY-ORIENTED MONITORING OF EQUITY IN HEALTH AND HEALTH CARE

Geneva, 29 September - 3 October 1997

PROGRAMME OF WORK

SPECIFIC OBJECTIVES

1. Share experiences with and discuss the strengths and weaknesses of a range of practical methods that have been used for policy-oriented monitoring of equity in health and health within countries, that are relevant to current needs of developing countries.

2. Develop a list of recommendations of indicators of health risk, health status, health resource allocation, and health care utilization that are available in existing/accessible data, and that seem particularly useful for policy-oriented monitoring of equity in developing countries at both national/provincial and district/local levels. Discuss corresponding equity targets at the appropriate national and subnational levels.

3. Review the equity component in the draft policy for Health for All in the 21st Century, including ethical considerations.

4. Recommend strategies WHO should be using to develop its work to promote equity in health and health care. This includes setting and monitoring progress toward measurable equity targets within as well as between countries, and overcoming obstacles to implementing policies to achieve equity targets

Monday 29 September

08.30 * **Registration**

09.00-09.45 * **Opening**
Address by the Director-General, Dr H. Nakajima.
Appointment of officers for the meeting and approval of agenda

09.45-10.30 * **Key-note presentation by Professor M.G. Marmot**
Monitoring as the basis for taking action. Personal experiences in the United Kingdom with trying to monitor equity in health and health care and the difficulty of getting from monitoring to policy/action.
Respondents: Dr E. LeFranc
Dr P. Kilima

10.30-11.00 Coffee

11.00-12.30 * **Discussion of different concepts of equity**
Chairperson: Dr D. Mukarji
Rapporteur: Dr Kauser Khan

12.30-14.00 Lunch

After lunch Monday through mid-Tuesday: Four sequential panels in plenary to present and discuss selected experiences with and issues in monitoring social inequalities in health status and health care within countries. The presentations will cover:
(i) identification of accessible and sustainable data sources;
(ii) selection of indicators of health risk, health status, health care resource allocation, and

health care utilization that are meaningful for monitoring equity;
(iii) quantitative and qualitative analytical approaches;
(iv) involvement of decision-makers and the public in defining the questions to be asked as well as in interpreting the potential implications of the findings and taking informed follow-up action;
(v) presentation of information simply and effectively to different audiences. Discussion will focus on issues of particular relevance for developing countries.

14.00-15.30 * **Panel #1: Monitoring of equity at the district and local level**

Moderator: Dr D. Kaseje
Rapporteur: Dr P. Barron

- Healthy Villages Initiatives as a strategy for ensuring equity: Dr O. Suleiman
- Methods to examine differentials in health and health care within cities and municipalities: Dr M. Barros
- District and local monitoring experiences on equity: Ms B. Sana Khan
- The use of regional and local indicators of socioeconomic circumstances, health and health care as basis for analysing equity. A Chilean methodological experience: Dr C. Gattini

15.30-16.00 Coffee

16.00-17.30 * **Panel #2**:**Using existing data sources to assess equity in health and health care in developing countries**.
Moderator: Dr R. Narayan
Rapporteur: Dr C. Montoya-Aguilar

- Examples of graphic presentations of information on equity in health care resource allocation, using routine data in Sri Lanka: Dr S. Dalpadhatu
- Use of living standards surveys to inform policy; examples from Senegal and Zambia: Mr F. Diop
- Selected examples of use of Demographic and Health Surveys to monitor equity in developing countries: Dr S.Rutstein
- The use of National Health Survey in Pakistan: Dr T. Akhtar

18.00 Reception

Tuesday 30 September

09.00-10.30 * **Panel #3**: **Challenges in monitoring equity in industrialized countries**
Moderator: Dr B. Starfield
Rapporteur: Dr S. Rutstein

- Challenges in measuring socioeconomic inequalities in health in the Netherlands and other countries of Western Europe: Dr A.Kunst
- Methodologic challenges in measuring social inequalities in health and health

care in the USA: Dr E. Pamuk
- Assessing data sources and indicators for monitoring equity in health and health care in Lithuania: Dr V. Grabauskas

10.30-11.00 Coffee

11.00-12.30 * **Panel #4: Experiences with measuring poverty and identifying the pockets of greatest need.**
Moderator: Dr G. Pappas
Rapporteur: Mr A. Preker

- Methods for identifying the poorest in Bangladesh: Dr B. Sen
- Experiences in Sri Lanka with measuring poverty and identifying the pockets of greatest need: Mr G. Gunatilleke
- Geographic Information Systems: a tool for targeting resources to the neediest: Ms K.P. O'Neill
- Using routine data to identify geographical inequities: Dr H. Rosling
- Identification of pockets of greatest need: Dr C. Montoya-Aguilar

12.30-14.00 Lunch

14.00- 15.30 * **Plenary: Equity targets and indicators to monitor the extent to which policy is moving toward the targets.**
Chairperson
- Experiences with setting and trying to move toward equity targets at global, regional, and national levels in Europe: Dr A. Ritsatakis
- Selecting indicators to monitor progress toward equity targets in developing countries: A framework: Dr P. Braveman

- **Respondent:** Dr N.Daniels

- Discussion

* **Introduction to working groups on indicators and targets**

15.30-16.00 Coffee

16.00-18.00 * **Working groups to develop recommendations on indicators and targets for policy-oriented monitoring equity in health and health care.**

Working group #1: Indicators and targets at local and district level
Moderator: Dr B. Starfield
Rapporteur: Dr P. Barron

Working group #2: Indicators and targets at provincial and national level
Moderator: Dr V. Grabauskas
Rapporteur: Dr Z.Padaiga

Working group #3: Indicators and targets at regional and global level
Moderator: Mr G. Gunatilleke
Rapporteur: Prof. R. Gillon

Working group #4: Obstacles to implementing policies on equity targets and strategies to overcome these. How can targets be used to enhance action?
Moderator: Dr P. Kilima
Rapporteur: Dr K. Khan

Wednesday 1 October

09.00-10.30 * **Working groups on indicators and targets** (continued)

10.30-11.00 Coffee

11.00-12.30 * **Plenary**: **Working groups on indicators and targets report back and discuss recommendations.**
Chairperson: Dr D. Mukarji

12.30-14.00 Lunch[4]

14.00-15.30 * **Plenary**: **Equity in the Draft Policy on Health for All in the 21st Century.**
Moderator: Dr J. Bryant
Rapporteur: Dr J. Gallagher

Overview of the equity component in the draft policy of Health for All in the 21st Century: Dr D. Yach

Discussion

15.30-16.00 Coffee

16.00-17.30 * **Plenary: Review/discussion of WHO's overall strategy on equity**, including activities in both policy-oriented monitoring and policy development/advocacy.
Chairperson: Dr D. Mukarji
Rapporteur: Dr R. Morrow

Country Perspective:	Dr R. Labode, Zimbabwe
WHO/Country Perspective:	Dr D. Arevshatian, WHO Representative/ Zimbabwe
WHO/Regional Perspective:	Dr E. Greene, PAHO
WHO/HQ Perspective:	Dr E. Tarimo, ARA
NGO Perspective:	Dr D. Mukarji

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[4] Note that a Technical Seminar will be held between 12.45 and 13.45 in Salle A on : **Measuring Health Inequalities : What is available**, by Dr A .E. Kunst, Erasmus University Rotterdam, The Nederlands. The moderator will be: Dr E. Tarimo, WHO/ARA.

* **Introduction to working groups on strategies on equity**

Thursday 2 October

09.00-10.30 * **Working groups to discuss recommended strategies for WHO activities to promote equity via both policy-oriented monitoring of equity and policy development/advocacy.**

Working group #1: Indicators and targets at local and district level
Moderator: Dr D. Kaseje
Rapporteur: Dr P. Barron

Working group #2: Indicators and targets at provincial and national level
Moderator: Dr R. Narayan
Rapporteur: Dr Z. Padaiga

Working group #3: Indicators and targets at regional and global level
Moderator: Mr G. Gunatilleke
Rapporteur: Prof. R. Gillon

Working group #4: Obstacles to implementing policies on equity targets and strategies to overcome these. How can targets be used to enhance action?
Moderator: Dr P. Kilima
Rapporteur: Dr K. Khan

10.30-11.00 Coffee

11.00-12.30 * **Working groups on strategies** (continued)

12.30-14.00 Lunch

14.00-15.30 * **Plenary: Working groups report back and discuss recommendations. Chairperson**

15.30 Afternoon free

Friday 3 October

09.00-10.30 * **Plenary: Review of report**

10.30-11.00 Coffee

11.00-12.30 * **Review of report** (continued)

Closure

MEETING ON POLICY-ORIENTED MONITORING OF EQUITY IN HEALTH AND HEALTH CARE

Geneva, 29 September - 3 October 1997

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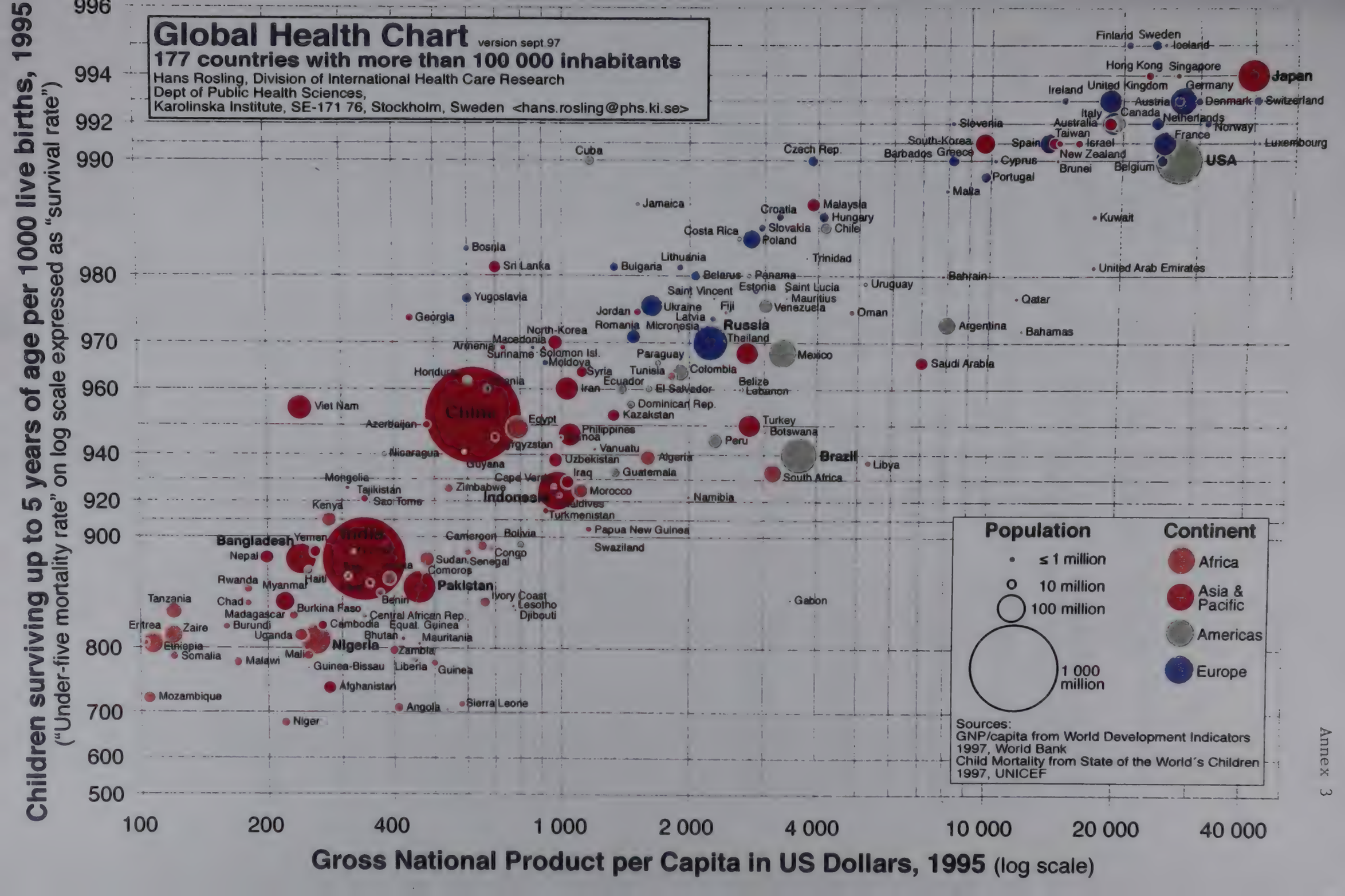
Global Health Chart version sept.97
177 countries with more than 100 000 inhabitants
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Children surviving up to 5 years of age per 1000 live births, 1995
("Under-five mortality rate" on log scale expressed as "survival rate")
Gross National Product per Capita in US Dollars, 1995 (log scale)
996
994
992
990
980
970
960
940
920
900
800
700
600
500
100
200
400
1 000
2 000
4 000
10 000
20 000
40 000
Finland
Sweden
Iceland
Hong Kong
Singapore
Japan
Ireland
United Kingdom
Germany
Austria
Denmark
Switzerland
Italy
Canada
Netherlands
Norway
Slovenia
Australia
Taiwan
France
South Korea
Spain
Israel
Luxembourg
Barbados
Greece
New Zealand
USA
Cyprus
Brunei
Belgium
Portugal
Malta
Cuba
Czech Rep.
Jamaica
Croatia
Malaysia
Hungary
Kuwait
Costa Rica
Slovakia
Chile
Poland
Bosnia
Lithuania
Trinidad
Sri Lanka
Bulgaria
Belarus
Panama
United Arab Emirates
Bahrain
Uruguay
Saint Vincent
Estonia
Saint Lucia
Mauritius
Yugoslavia
Qatar
Jordan
Ukraine
Fiji
Venezuela
Oman
Georgia
Latvia
Russia
Romania
Micronesia
Thailand
Argentina
Bahamas
North-Korea
Macedonia
Armenia
Suriname
Solomon Isl.
Paraguay
Mexico
Moldova
Saudi Arabia
Syria
Tunisia
Colombia
Ecuador
Belize
Iran
El Salvador
Lebanon
Dominican Rep.
Viet Nam
China
Kazakstan
Azerbaijan
Egypt
Turkey
Philippines
Botswana
Peru
Vanuatu
Nicaragua
Brazil
Uzbekistan
Algeria
Libya
Guyana
Iraq
Guatemala
South Africa
Mongolia
Cape Verde
Tajikistan
Zimbabwe
Indonesia
Morocco
Namibia
Kenya
Sao Tome
Maldives
Turkmenistan
India
Papua New Guinea
Bangladesh
Yemen
Cameroon
Bolivia
Swaziland
Nepal
Congo
Sudan
Senegal
Comoros
Rwanda
Myanmar
Haiti
Pakistan
Tanzania
Chad
Benin
Ivory Coast
Lesotho
Gabon
Djibouti
Burkina Faso
Madagascar
Central African Rep.
Eritrea
Zaire
Burundi
Cambodia
Equat. Guinea
Uganda
Bhutan
Mauritania
Ethiopia
Nigeria
Zambia
Somalia
Malawi
Mali
Guinea-Bissau
Liberia
Guinea
Afghanistan
Mozambique
Angola
Sierra Leone
Niger
Population
≤ 1 million
10 million
100 million
1 000 million
Continent
Africa
Asia & Pacific
Americas
Europe
Sources:
GNP/capita from World Development Indicators 1997, World Bank
Child Mortality from State of the World´s Children 1997, UNICEF

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